**Societal Aspects of Interviewing and the Physician – Patient Relationship**

**The Framework Used for Clinical Decision-­‐Making Over Time**

**Experience**-based Medicine

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**Knowledge**-based Medicine

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**Evidence**-based Medicine

(you don’t just do what you think will be effective you do what has been proven to be effective)

↓

**Values**-based Medicine

(taking the body of evidence and apply it to the person in front of me; persons centered approach)

***Culture***

* “A set of learned and shared beliefs and values, that are applied to social interactions and the interpretation of experiences”
* Framework that shapes and directs how we behave and manner in which we interpret behaviors of others
* Influences how we *experience* illness and how we *express* illness, pain and our own health care decisions
* **Our Culture in Medicine**
  + Convenience based on our needs or those we are here to help?
  + Hospital rounds at 5:30a.m.
    - We do this because it works for the doctors schedule especially surgeons
  + Mandatory attire while hospitalized
    - Helps to differentiate doctors but it is intimidating to the patient
  + Curtains for privacy
    - Really only works for visual privacy
  + Parking’ in hallways between diagnostic tests
    - Allows hospitals to get a lot done but it is uncomfortable for the patient sometimes
* **Multiple Dimensions of Culture in Medicine**
  + Privacy
  + Communication
  + Socioeconomic status
    - Some people will come in and treat doctors poorly based on assumptions
  + Immigration / citizenship status
  + Approach to making decisions
  + Beliefs explaining health and illness
  + Focus of attention (on illness instead of wellness)
    - In the US we focus more on illness
    - Some companies are moving toward wellness
  + Healing traditions (and the individuals involved / excluded, in those traditions)
* **Understanding ‘Sickness’ and Return to Health - Examples**

|  |  |  |
| --- | --- | --- |
|  | **Sickness** | **Health** |
| **Yin & Yang** | Disturbance in balance caused by emotions, too much or too little heat or cold | Restoration of balance to body or mind |
| **Soul loss / theft** | Soul has left body or has been stolen | Return of soul to body (Shaman leaves his or her body to search for missing soul) |
| **Spirit or demon possession** | Body taken over by evil spirit(s) | Exorcism or placation of evil spirits with help of sorcerer |
| **“What is your understanding?”** | “How do you know when you are sick?” | “How do you attempt to restore health when you are not well?” |

***Disease* vs. *Illness***

* ***Disease***
  + Theoretical construct, or abstraction, by which we attempt to explain an individual’s problems
  + Defined in terms of structure and/or function of body organs and systems
  + Physiology
* ***Illness*** 
  + Individual’s personal experience of ill health

**Explanations for Disease**

* “Disease results from...”
  + Supernatural causes
  + Certain beliefs, spirits, misdeeds or lack of faith
    - “I stopped going to church…”
  + An imbalance between living entities and a variety of factors (e.g., energy, nature, a higher power, etc.)
  + Various biological influences (e.g., genes, bacteria, carcinogens, etc.)
  + How do ***you*** explain disease?

**Types of Explanatory Models**

* Moral
  + Ive done bad things therefore I deserve to be sick
* Spiritual / religious
  + This is gods punishment
* Magical
  + Evil spirits
* Medical
  + Western allopathic medicine
  + Traditional Chinese medicine
  + Homeopathy
  + Ayurvedic medicine
  + Osteopathy
  + Various types of ‘herbal medicine’

**Potential Consequences of Conflicting Explanatory Models**

|  |  |
| --- | --- |
| **Conflict** | **Consequences** |
| Patient – physician → | Diminished rapport, treatment non-adherence, treatment termination |
| Patient – family → | Lack of support, shame, family discord |
| Patient – community → | Social isolation, stigmatization |

* Patient-physician
  + Direct relationship
* Patient-family
  + If a person is in ICU then you usually have to work with the family
  + You should know their beliefs to prevent conflict
* Patient-community
  + If yours doing something that’s at odds with that society that your patient interacts and you need to know how this is going to fit with how he/she is living her daily life

**Understanding of Disease -­‐ WHO**

* “Anything less than a complete state of physical, social and mental well- being”

**Understanding of Disease -­‐ FDA**

* “Any deviation from, impairment of or interruption of the normal structure or function of any part, organ or system ... of the body... manifested by a characteristic set of one or more signs or symptoms, including laboratory or clinical measurements that are characteristic of a disease”

**Understanding of Disease -­‐ Navajo**

* “Lack of harmony in and with the universe”

**Aspects of Cultural Identity**

* Ethnicity
* Race
* Country of origin
* Language
* Gender
* Age
* Marital status
* Sexual orientation
* Religious / Spiritual beliefs
* Socioeconomic status
* Education
* Migration history
  + Often doesn’t get asked
  + How they came from whatever country they came from
* Level of acculturation
  + Is it someone who is living in a more circumscribed community within their city
  + Or is it someone who is trying to leave behind their culture
* Other

**Ethnicity**

* Subjective
* Self-defined
* Relates to each individual’s identity with a group
* May be through nationality, shared history, religion, cultural patterns, etc.

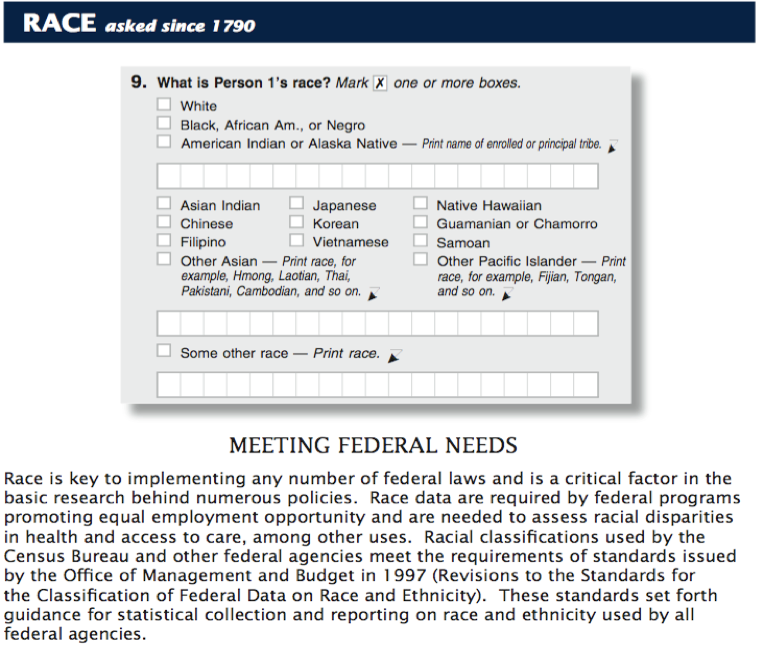
**Geographic Ancestry**

* Objective
* Refers to genetic relationships
  + Between individuals
  + Among populations
* Considered to be more accurate in helping to determine biological risk factors than is race alone

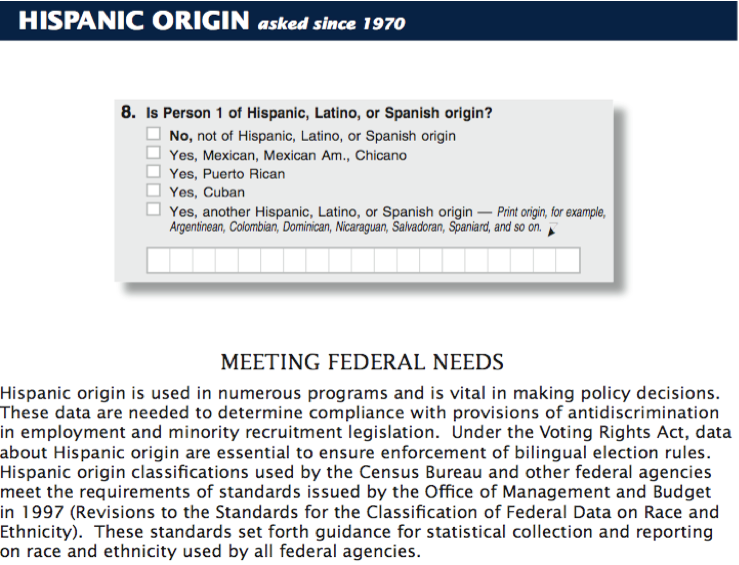
**Race and Geographic Ancestry**

* Race might co-vary with different environmental or genetic factors that underlie risk for disease
* Race often used to make inferences about individual’s genetic ancestry and to predict specific genetic risk factors
* Genetic ancestry highly correlated with geographic ancestry, but correlation with race is modest

**U.S. Census Bureau – Race (2010)**

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**U.S. Census Bureau – Ethnicity (2010)**

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**U.S. Census Bureau – Race and Ethnicity Categories (1980)—don’t need to know these**

* Four *racial* categories:
  + “American Indian or Alaskan Native”
  + “Asian or Pacific Islander”
  + “Black”
  + “White”
* Two *ethnicity* categories:
  + “Hispanic origin”
  + “Not of Hispanic origin”

**U.S. Census Bureau – “Single Race Alone” Categories (2000)—don’t need to know these**

* Six mutually exclusive racial categories:
  + “White”
  + “Black or African American”
  + “American Indian or Alaska native”
  + “Asian”
  + “Native Hawaiian or other Pacific Islander”
  + “Some other race”

**U.S. Census Bureau – Final Race Categories (2000)—don’t need to know these**

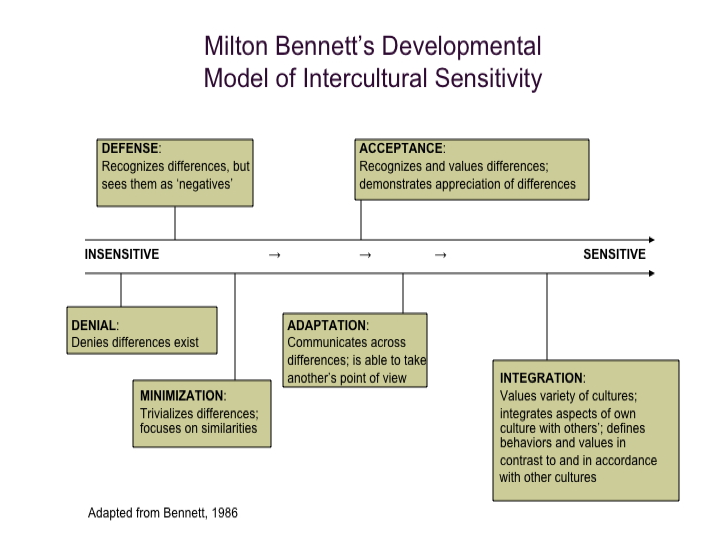
* Six “single race alone”
* “Two or more races” contained all multi-  race responses
* Population counted was categorized as follows:
  + 6 “Single race alone” categories
  + +15 Categories of “2 Races”
  + +20 Categories of “3 Races”
  + +15 Categories of “4 Races”
  + +6 Categories of “5 Races”
  + +1 Category of “6 Races”
  + **63 Possible combinations**

**U.S. Census Bureau – Ethnicity Categories (2000)**

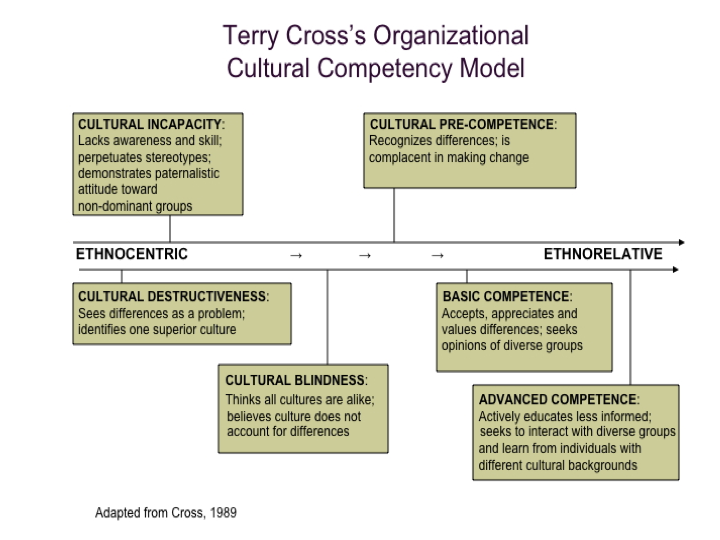
* Two ethnicity categories:
  + “Hispanic or Latino”
  + “Not Hispanic or Latino”
* “Hispanic and Latino individuals may be of any race”

**U.S. Census Bureau – Race and Ethnicity Categories (2010)**

* Saw much more diverse categories in specifying one’s race

**Race and Health Disparities**

* Health disparities are population- specific differences related to:
  + Access to care
    - Depends on where you grew up
  + Utilization of resources
    - And also how we choose to allocate resources
  + Health outcomes
    - Direct correlation to having access to health care (poverty level) and health outcomes
  + General health
  + Barriers to optimal health
* Race plays a role in creation and maintenance of health disparities

**Cultural Competence**

* Results in active application of awareness, knowledge and skills in health care delivery
  + Don’t be afraid to challenge your superiors and make sure that your moving toward ethnorelativity and away from ethnocentricity
* (Usually) does not occur naturally
* Moves us to the other end of the continuum, away from ethnocentricity (in which we use our own cultural ‘rules’ to judge people who are different from us)

**Cultural Competence in Medical Practice**

* Includes knowledge, skills and attitudes
* Enhances physician’s:
  + Understanding / respect for individual’s values, beliefs and expectations
  + Awareness of own assumptions and values
  + Awareness of assumptions and values that are embedded in the U.S. system of health care delivery
  + Ability to adapt approach in meeting the needs of individual patients
    - Meeting their specific needs as an individual
* **Does not** require extensive knowledge of different cultures
* **Does** require an intentional, thoughtful and systematic approach to delivering person-centered health care

**Benefits of Cultural Identity Assessment**

* Identification of potential strengths and support
* Identification of potential vulnerabilities
  + Patients already are vulnerable so its important to be able to pick out situations with increased vulnerability too
* Identification of potential areas of  cultural conflict
* Better appreciation for patient’s perspective
* Assistance in building rapport with patient

**“How** **do you know when you need to seek medical attention for a problem?”**

* When praying or asking for help from a higher power doesn’t work?
* When you can’t get out of bed?
* When you can’t complete your usual  tasks or fulfill your responsibilities?
* When you can tell that something ‘just isn’t right’?
* How do **you** know?

***Stereotypes* and *Generalizations***

* ***Stereotype***
  + Ending point
    - You already know what you want to know about that individual
  + No attempt is made to learn if individual ‘fits’ your assumption
* ***Generalization*** 
  + Starting point
  + More information is  collected to check ‘fit’ with assumption

***Spirituality* and *Religion***

* ***Spirituality***
  + Individual’s sense of the transcendent
  + Sense that there is something bigger than self
  + Many components
* ***Religion***
  + Adherence to a faith tradition in practice, belief or both
  + Constructed by a community of believers
    - Something groups of people do together
  + Many components, but cannot assume that spirituality is one of them

**Religion**

* Adherence to a faith tradition in…
  + Practice
    - Easy to measure
    - Outward expression of the tradition
    - “Religiosity” and / or
  + Belief
    - Very difficult to measure
    - Acceptance of doctrine
    - Usually changes individual’s behavior

**Complex Assumptions re: Religion, Spirituality and Nationality –**

* **Example**
  + “With regard to religion, most Chinese, Japanese, Korean, and Vietnamese worship their ancestors, follow Confucian teachings, and believe in Mahayana Buddhism. Many Japanese Americans follow Shintoism and Zen Buddhism. Most Filipino Americans are Catholic. More than 70% of Koreans in the United States are Protestant
    - The speakers friends said they “venerate their ancestors not worship them”
  + “...Most Hmong and Mien believe in animistic and supernatural causes. The Cambodians and Laotians are followers of Brahmanism of the Hindus and Theravada Buddhism (Ross 1990; Savada 1995). Among Asian Indians, Hinduism is the major religion (Juthani 1992; Prathikanti 1997). The Pakistanis are mostly followers of Islam.”

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| --- | --- | --- |
| **Religion** | **Beliefs** | **Clinical Consequences** |
| **Confucianism** | Emphasis is on reciprocity, benevolence, filial piety, respect for authority, self-­‐development, scholarship.  \**Harmony above all* | Elder brother, parents may discourage patient from taking medications. |
| **Buddhism** | Human life is full of sorrows caused by family’s deeds, one’s own karma and expectations, or one’s desires.  \**something that is alive responds to light to Buddhists* | Patient may accept illness in a fatalistic manner and passively do nothing. |
| **Taoism** | **Yin** is the female energy, representing softness, darkness, and coldness. **Yang** is the male energy, representing strength, lightness, and heat. Balance is achieved by moving the vital energy qi (or chi). | Patient may seek alternative healing methods to balance qi (or chi). |

**Case Discussion**

**Kleinman’s Questions**

* (Used in eliciting an individual’s explanatory model)
* 1.  What do you call the problem?
* 2.  What do you think has caused the problem?
* 3.  Why do you think it started when it did?
* 4.  What do you think your sickness does? How does it work?
* 5.  How severe is your sickness? Will it have a short or long course?
* 6.  What kind of treatment do you think you should receive?
* 7.  What are the most important results you hope to receive from this treatment?
* 8.  What are the chief problems the sickness has caused?
* 9.  What do you fear most about the  sickness?

**The LEARN Model—get an idea of when to use each one**

* **L**
  + Listen with sympathy and understanding to the individual’s perception of the problem
* **E** 
  + Explain your perception of the problem
* **A**
  + Acknowledge and discuss the differences and similarities
* **R** 
  + Recommend treatment / solution
* **N**
  + Negotiate an agreement
    - Because if you do something that isn’t going to fit with that persons worldview or understanding than that patient will not go along with your recommendations

**The RESPECT Model— get an idea of when to use each one**

* **R—Rapport** 
  + Connect interpersonally
  + Recognize and avoid making assumptions
  + Attempt to view the situation from the individual’s point of view
  + Be deliberate in your attempt to suspend judgment
* **E—Empathy** 
  + Remember that individual has come to you for help
  + Seek out and understand individual’s rationale for behaviors or illness
  + Verbally acknowledge and legitimize individual’s feelings
* **S—Support** 
  + Ask about / try to understand barriers to care and treatment adherence
  + Help individual overcome barriers
  + Involve family members when  appropriate
  + Reassure about your availability to help
* **P—Partnership**
  + Be flexible regarding issues of control
  + Negotiate roles when necessary
  + Stress collaborative approach in  addressing problem
* **E—Explanations**
  + Check individual’s understanding  (frequently)
  + Use verbal clarification techniques
* **C—Cultural Competence** 
  + Respect individual, culture and beliefs
  + Understand that individual’s views of medicine and physicians may be defined by ethnic or cultural influences (and past experiences)
  + Be aware of your own biases and preconceptions
* **T—Trust**
  + Understand that self-disclosure may be difficult for some individuals
  + Try to establish a therapeutic relationship based on trust

**Psychiatry’s DSM-IV Outline for Cultural Formulation**

* 1.  Cultural identity of individual
* 2.  Cultural explanations of individual’s illness
* 3.  Cultural factors related to (psychosocial) environment and level(s) of functioning
* 4.  Cultural elements of relationship between individual and clinician
* 5.  Overall cultural assessment for diagnosis and care

**The Therapeutic Triad When Utilizing Interpreters**



**Educational Objectives**

1. Discuss the importance of attempting to deliver person-centered care
2. Define culture and discuss its various dimensions in medicine
3. Discuss the difference between *disease* and *illness*
4. Describe how culture relates to health... and illness
5. Discuss the relationship between effective communication and delivery of quality health care
6. Describe two models used to promote cultural understanding in the practice of medicine
7. Explain why physician–patient negotiation is important